STATE-BOSTON RETIREMENT SYSTEM

Boston City Hall, Room 816
Boston, Massachusetts 02201
617-635-4305
617-635-4318 – Fax
http://www.cityofboston.gov/retirement

NEW MEMBER ENROLLMENT FORM

Section A: To be filled out by employee.
1. (Please print or type, except for signature.)

Name:_____		Former Name:_____		SSN:_____
Street Address:_____			D.O.B:_____	Gender:_____
City:_____	State:_____	Zip:_____	Phone #:_____	
Marital Status ☐ Married ☐ Single ☐ Widowed ☐ Divorced			Spouse D.O.B:_____	Number of Children:___
Are you a Veteran? ☐ Yes ☐ No			Position:_____ Start Date:_____	
Dates of Military Service:_____			Agency or Department:_____	
A COPY OF A MILITARY DISCHARGE MAY BE REQUESTED			Agency Phone #:_____	

The retirement law establishes specific periods of active service, which may qualify you for certain Veteran benefits.

2. Past membership history with any other contributory retirement system in Massachusetts.

RETIREMENT SYSTEM	**FROM**	**TO**	**WAS REFUND TAKEN**	
_____	_____	_____	☐ **YES**	☐ **NO**
_____	_____	_____	☐ **YES**	☐ **NO**
_____	_____	_____	☐ **YES**	☐ **NO**
_____	_____	_____	☐ **YES**	☐ **NO**

You may be eligible to purchase your Prior Service if a Refund was taken.

3.

Are you currently or have you ever received a retirement allowance from another public retirement system? ☐ Yes ☐ No

4. Statement and Signature By Member

I certify the above information to be true and correct to the best of my knowledge and hereby accept membership in the State-Boston Retirement System. This statement is signed under penalties of perjury.

Date:_____ **Signature** _____

Section B: BENEFICIARY INFORMATION (To be filled out by employee.)

Beneficiary or beneficiaries nominated will receive in the proportion designated any sum due at your death. The right to change any nominated beneficiary is reserved by the member.

NOTE: A BENEFICIARY BLANK WITH CORRECTIONS OR ERASURES IS NOT ACCEPTABLE

GIVE COMPLETE NAME AND ADDRESS OF EACH BENEFICIARY	BENEFICIARY D.O.B. & SS#	RELATIONSHIP to MEMBER	PROPORTION of BENEFIT*
Name: _____ Address: _____	_____ _____	_____	_____ PRIMARY
Name: _____ Address: _____	_____ _____	_____	_____ PRIMARY
Name: _____ Address: _____	_____ _____	_____	_____ PRIMARY
Name: _____ Address: _____	_____ _____	_____	_____ PRIMARY
Name: _____ Address: _____	_____ _____	_____	_____ PRIMARY

*** Must Total 100% -- If Contingent Please Specify**

(A CHANGE OF BENEFICIARY FORM must be used if you wish to change your designated beneficiary/beneficiaries. You may obtain this form from your personnel/payroll department or from this office.)

Date: _____ **Signature** _____

Signature of Witness _____

Section C: DEPARTMENTAL INFORMATION (To be filled out by Department/Agency Representative and verified by Retirement Board.)

POSITION		DEDUCTION	SERVICE STATUS
_____		☐ 5%	☐ Full-Time
Start Date: _____		☐ 7%	☐ Part-Time Pct:
_____		☐ 7% + 2%	☐ Temp./Sub.
Start Date: _____		☐ 8% + 2%	☐ Other _____
_____		☐ 9% + 2%	_____
Start Date: _____		☐ 11% (Tarp)	Tarp Start Date: _____
Date of First Deduction:	☐ New ☐ Transfer	(TARP) Teachers' Alternative Retirement Program	

Department / Agency Name: _____ Payroll Number: _____

Authorized Signature: _____ Date _____

Verified by Retirement Board: _____